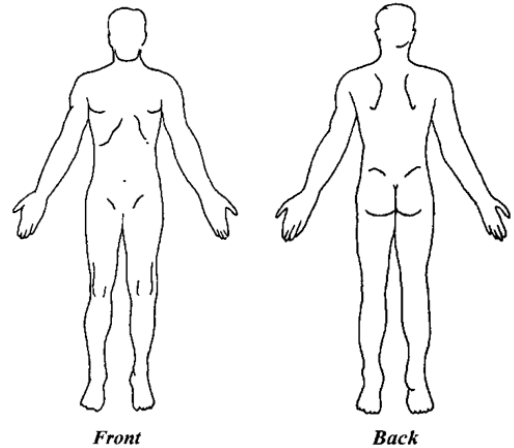


Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI \_\_\_\_\_ Date: \_\_\_\_\_

Daytime Phone Number: \_\_\_\_\_ Evening or Other Phone: \_\_\_\_\_

**Pain Location:**

<input type="checkbox"/> Back Pain	
<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Neck Pain	
<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Please indicate location of pain on diagrams to the right:	
<p>Has the location of your pain changed since your last visit? If so, where?</p>	



**Has your pain changed since the last visit?**

<input type="checkbox"/> Decreased
<input type="checkbox"/> Increased
<input type="checkbox"/> Stayed the same

<input type="checkbox"/> I had an injection at my last visit. I had _____ % relief that lasted _____
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**Severity— overall. Intensity: Rate 0-10.**

<input type="checkbox"/> mild Current _____	<input type="checkbox"/> moderate Best _____	<input type="checkbox"/> mod-severe Worst _____	<input type="checkbox"/> severe
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**Medication. Have there been any medication changes since your last visit? If so, please list:**

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**Timing.**

	<input type="checkbox"/> constant	<input type="checkbox"/> intermittent	<input type="checkbox"/> occasional
Worst in:	<input type="checkbox"/> morning	<input type="checkbox"/> evening	<input type="checkbox"/> night

**Pain Quality.**

<input type="checkbox"/> burning	<input type="checkbox"/> dull-aching	<input type="checkbox"/> sharp	<input type="checkbox"/> throbbing
<input type="checkbox"/> cramping	<input type="checkbox"/> pressure-like	<input type="checkbox"/> shooting	<input type="checkbox"/> numbness
<input type="checkbox"/> pins and needles	<input type="checkbox"/> other: _____		

**System Review:**

POSITIVE RESPONSE ONLY

Do you have joint stiffness?.....	<input type="checkbox"/> Which joint? _____
Restriction of motion?.....	<input type="checkbox"/> Where? _____
Pain in an extremity?.....	<input type="checkbox"/> Which extremity? _____
Swelling?.....	<input type="checkbox"/> Where? _____
Do you frequently have dizziness?.....	<input type="checkbox"/>
Memory loss?.....	<input type="checkbox"/>
Seizures or convulsions?.....	<input type="checkbox"/>
Paralysis or muscle weakness?.....	<input type="checkbox"/> Which muscle/where? _____

**Activity Scale:**

Are you NOT able to perform the following activities of daily living? Check all that apply:

<input type="checkbox"/> Going to work	<input type="checkbox"/> Socializing with friends
<input type="checkbox"/> Performing household chores	<input type="checkbox"/> Participating in recreational activities
<input type="checkbox"/> Shopping	<input type="checkbox"/> Exercising

Physician Notes: